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April 2, 2018

Ajit Pai, Chairman
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

RE: Request for Waiver of USAC Funding Cap for 2017 Funding

Dear Mr. Pai,

Please find enclosed for filing, on behalf of our client, Bristol Bay Area Health Corporation ("BBAHC"), a Request for Review to the Commission requesting full waiver of the Commission's regulatory funding cap on the Universal Service Fund Rural Health Care program and its application to BBAHC by the Universal Service Administrative Company ("USAC").

On March 16, 2018, BBAHC received funding commitment letters from USAC stating BBAHC's 2017 funding would be reduced by a proration of 84.40458%. BBAHC was substantially impacted by this denial of 2017 funding. The proration by USAC will result in an increase in cost of more than $4 million to BBAHC.

We request that the Commission issue a written decision in response to this request within 90 days pursuant to 47 C.F.R. 54.724(b).

Thank you for your consideration of this matter.

Sincerely,

HOBBS, STRAUS, DEAN & WALKER, LLP

By: _____
Geoffrey D. Strommer

CC: Robert J. Clark, President/CEO, BBAHC
Universal Service Administrative Company, Rural Health Care Division

Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Request for Review by	)	WC Docket No. 02-60
Bristol Bay Area Health Corporation	)	
of Decision of	)	
Universal Service Administrator	)	
	)	
HCP Nos. 10974, 10981, 11005	)	
	)	

FCC WAIVER REQUEST MADE BY BRISTOL BAY AREA HEALTH CORPORATION

The Bristol Bay Area Health Corporation ("BBAHC") hereby requests that the Federal Communications Commission ("FCC" or "Commission") waive the application of its regulation found at 47 C.F.R. § 54.675(a) ("Regulatory Cap") which imposes a cap of $400 million on Universal Service Fund ("USF") funding for the Rural Health Care ("RHC") program. This waiver is required by the Telecommunications Act of 1996 ("Act"), which mandates full funding of the RHC program. BBAHC further requests that FCC reverse the recent decisions of the Universal Services Administrative Company ("USAC" or "Administrator") made in Funding Commitment Letters ("FCLs") issued March 16, 2018 to BBAHC[1] to partially deny 2017 Funding Year ("FY 2017") RHC funding to BBAHC due to demand exceeding the Regulatory Cap.

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[1] As of the date of this filing, USAC has not responded to all of BBAHC's FY 2017 funding requests, and one 2016 Funding Year ("FY 2016") funding request (FRN 16886241) that still remains outstanding (FY 2016 had a different proration by USAC). BBAHC will supplement this Waiver Request when it has received the outstanding Funding Commitment Letters. Nonetheless, the substantial impact of the proration decision is known and ripe for review.

I. Introduction and Background

Bristol Bay Area Health Corporation (BBAHC) provides health care services to Alaska Natives and other beneficiaries pursuant to the Alaska Tribal Health Compact ("ATHC"), a multi-party self-governance agreement between the United States Indian Health Service ("IHS") and Alaska Tribes and Tribal organizations under Title V of the Indian Self-Determination and Education Assistance Act ("ISDEAA"), 25 U.S.C. § 5381, *et seq*. The ATHC authorizes its co-signers, such as BBAHC, to provide health care services to IHS beneficiaries and others pursuant to the terms of the ATHC and Funding Agreements ("FA") with the IHS.

BBAHC operates clinics in the extremely remote Bristol Bay region of Alaska, serving Alaska Natives and others in Bristol Bay as well as in isolated villages. For most of these villages, many of which are accessible only by air and sea, BBAHC's clinics provide the only health care services available. BBAHC relies heavily on telemedicine to provide services to these villages. The extreme remoteness of these clinics results in punishingly high costs of infrastructure for internet connectivity required for telemedicine, electronic health records and other mission critical services, and BBAHC depends on the reimbursement provisions of the Universal Service Fund Rural Health Care program to pay for these costs.

On March 16, 2018, USAC responded to BBAHC's Funding Requests ("FR") with Funding Commitment Letters ("FCL") that reduced the funding to which BBAHC is entitled by a proration of 84.40458%. This funding denial in the form of a proration, when applied to each of BBAHC's FRs, will total more than $4 million of lost funding in funding year 2017. USAC's denial has created an emergency budget situation for BBAHC that, without the FCC's granting of the relief sought here, will lead to program cuts, layoffs, and a disruption of mission critical

services that will unquestionably result in injury and loss of life within the eligible populations served by BBAHC.

In funding year 2017, BBAHC, along with other rural Health Care Providers ("HCPs"), received a similar but lower proration of their funding year 2016 FRs, also on the basis of the Regulatory Cap. BBAHC appealed to USAC to review and reverse the funding year 2016 FCL funding denial. That appeal, filed on June 12, 2017, was never addressed by USAC.[2]

The FCC and USAC erred in applying an across-the-board *pro rata* reduction in RHC funding due to the $400 million Regulatory Cap that the Commission arbitrarily imposed, thus eliminating any opportunity for full funding for the services BBAHC requested in its Form 465 and Form 466 funding requests. Neither USAC nor FCC has determined that BBAHC failed to meet all requirements of the RHC funding mechanism, and USAC was therefore statutorily required to commit funding for the Funding Requests summarized in Exhibit A.

BBAHC hereby requests that FCC waive the application of the Regulatory Cap to BBAHC's funding year 2017 FRs, direct the USAC Rural Health Care (RHC) Division to vacate its decisions to deny funding for the FRs referenced in Exhibit A, and fully fund BBAHC's funding year 2017 FRs.

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[2] USAC never responded to BBAHC's funding year 2016 appeal. The FCC issued a waiver that allowed the telecommunications carriers providing services funded by the RHC program to waive, or forgive, the difference between the "total funding amount" and the "committed," or prorated, funding amount. *See* Rural Health Care Support Mechanism, WC Docket No. 02-60, Order, 32 FCC Rcd. 5463, 5465, para. 9 (2017) ("Alaska Waiver Order"). This is not a sustainable solution, and BBAHC and other tribal health providers cannot rely on such losses being absorbed by the carriers in the future.

II. Statement of Interest

BBAHC appeals to the Commission pursuant to 47 C.F.R. § 54.719(c), which provides that "Parties seeking waivers of the Commission's rules shall seek relief directly from the Commission." The FCC promulgated the Regulatory Cap on March 1, 2013. 78 Fed. Reg. 13,992 (codified at 47 C.F.R. § 54.675). USAC has no authority to waive an FCC regulation.[3] 47 C.F.R. § 54.702(c). However, FCC regulations expressly provide that the Commission may waive any provision of its rules "if good cause therefor is shown." 47 C.F.R. § 1.3. Because the FCC, and not USAC, has authority to waive FCC's Regulatory Cap on the basis that the cap is beyond the authority delegated by Congress in the Telecommunications Act, the Commission has sole jurisdiction over this appeal. Further, because the legal issue underlying this appeal – the legality of the Regulatory Cap pursuant to the Telecommunications Act – "involves novel questions of fact, law, or policy," BBAHC is entitled to review by the full Commission. 47 C.F.R. § 54.722(a).

This appeal is timely filed within sixty days of the USAC decision in the March 16, 2018 BBAHC FY 2017 Funding Commitment Letters. 47 C.F.R. § 54.720.

III. Statement of Facts

The BBAHC Form(s) 465 referenced in Exhibit A were timely submitted on behalf of BBAHC to fund the provision of services at clinics that provide health care for BBAHC member Tribes' populations as well as other eligible beneficiaries.

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[3] 47 C.F.R. § 54.702(c) states, "The Administrator may not make policy, interpret unclear provisions of the statute or rules, or interpret the intent of Congress. Where the Act or the Commission's rules are unclear, or do not address a particular situation, the Administrator shall seek guidance from the Commission."

On March 16, 2018, FY 2017 FCLs were issued by USAC. In those FCLs, USAC, repeating its distinction first made in the FY 2016 FCLs, distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The note indicated by USAC's asterisk stated the following: "The pro-rata factor for this filing window period is 84.40458%."

USAC approved funding for BBAHC through the FCLs at the rate of 84.40458% of the amount requested, resulting in the denial of funding for the underlying funding requests in an amount exceeding $4 million. The exact amount will be determined once all the FCLs are received. The application of a *pro rata* percentage of funding by USAC constituted a partial denial of funding, even if USAC does not characterize the proration as a funding denial.

Exhibit A lays out in detail each of the three BBAHC FRs for which BBAHC has received an FCL to date for funding year 2017. Exhibit A provides the Service Provider, Health Care Provider, Form 465 Application Numbers, Funding Request Numbers, and total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the *pro rata* formula, received by BBAHC as of the date of this filing. Exhibit B contains the FCLs received thus far themselves.

BBAHC's funding requests and the total funding amounts approved by USAC comply with applicable law and the FCC's requirements, but the arbitrarily created category of "Committed Funding," based upon a *pro rata* formula implementing the Regulatory Cap, is contrary to applicable law and policy.

IV. Question Presented for Review

Does the Commission's Regulatory Cap at 47 C.F.R. § 54.675, which imposes a $400 million funding cap on the Universal Service Fund Rural Health Care program, and USAC's application of the cap by prorating BBAHC's mandatory funding requests, exceed the authority

delegated to the Commission by Congress pursuant to the Telecommunications Act of 1996, 47 U.S.C. § 254?

V. Discussion

FCC and USAC impermissibly acted beyond the boundaries of statutory and congressionally delegated authority when FCC promulgated the Regulatory Cap and USAC prorated BBAHC's statutorily required funding. The Regulatory Cap violates the Telecommunications Act, the FCC's own 1997 Universal Service Order, and the trust responsibility of the federal government to provide health care to American Indians and Alaska Natives, as articulated by the FCC in its 2000 Tribal Policy Statement.

The Telecommunications Act of 1996, 47 U.S.C. § 254

Section C of the Telecommunications Act is written unambiguously as a mandatory program that includes USF funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress required carriers to provide rural HCPs necessary services at rates comparable to urban areas, and, in turn, required the FCC to reimburse carriers on behalf of rural HCPs:

> A telecommunications carrier shall, **upon receiving a bona fide request**, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State. A telecommunications carrier providing service under this paragraph **shall be entitled to have an amount equal to the difference**, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State **treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.**

47 U.S.C. § 254(h)(1)(A) (emphasis supplied).

Examination of the plain language of the Act, and its use of the word "shall" in the operative phrase that carriers "shall be entitled to have an amount equal to the difference" between rates reveals that USF payments to the carriers by USAC are mandatory, not optional. "[T]he starting point for interpreting a statute is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive." *O'Hara v. Teamsters Union Local No. 856*, 151 F.3d 1152, 1160 (9th Cir. 1998) (*quoting Continental Cablevision, Inc. v. Poll*, 124 F.3d 1044, 1048 (9th Cir.1997)). Congress' use of "shall" in the statute signals a mandatory command to the FCC and USAC. *Ass'n of Civilian Technicians, Montana Air Chapter No. 29 v. Fed. Labor Relations Auth.*, 22 F.3d 1150, 1153 (D.C. Cir. 1994) ("The word "shall" generally indicates a command that admits of no discretion on the part of the person instructed to carry out the directive")(emphasis supplied).

FCC Regulation 47 C.F.R. § 54.675 – The Regulatory Cap

Despite the Act's statutory mandate, FCC departed from the statute in implementing 47 C.F.R. § 54.675 in two ways that injured BBAHC and similarly situated HCPs. First, the regulation imposed a $400 million Regulatory Cap on the amount available for the program, with no statutory support and in derogation of the Act's funding mandate, creating an artificial shortfall and injuring the HCPs. Second, Section 54.675 impermissibly realigned the statutory relationships between the Administrator, HCPs and carriers to force the HCPs, rather than the carriers, to bear the burden of that shortfall.

When an agency acts "beyond the bounds of its statutory authority," it is not entitled to deference. *Pharm. Research & Manufacturers of Am. ("PHRMA") v. United States Dep't of Health & Human Servs.*, 43 F. Supp. 3d 28, 40 (D.D.C. 2014). "It is axiomatic that an administrative agency's power to promulgate legislative regulations is limited to the authority

delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). "No matter how it is framed, the question a court faces when confronted with an agency's interpretation of a statute it administers is always, simply, whether the agency has stayed within the bounds of its statutory authority." *PHRMA,* 43 F. Supp. 3d at 36 (*quoting City of Arlington, Tex. v. F.C.C.*, 569 U.S. 290, 295 (2013)).

FCC's rulemaking authority in this case is limited to making changes in FCC regulations implementing the requirements of 47 U.S.C. § 214(e), which governs the USF program.[4] That authority does not extend to restricting funding to rural HCPs with an annual $400 million cap or requiring *pro rata* distribution of funds to applicants if the cap is exceeded.

In *In Re FCC 11-161*, the Court of Appeals for the Tenth Circuit considered various challenges to the FCC's rulemaking related to the USF. *In re FCC 11-161*, 753 F.3d 1015 (10th Cir. 2014). The majority of that Tenth Circuit panel deferred to the FCC in each challenge on the basis that Congress had delegated broad authority in the matters raised by petitioners, reasoning that the Telecommunications Act used broad language and left statutory gaps for the FCC to fill.[5]

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[4] That rulemaking authority in 47 U.S.C. § 254(a) requires the FCC, in accordance with recommendations of a Federal-State Board, to change FCC regulations in order to implement § 214(e) of the Act. Section 214(e)(1) governs the provision of universal service by: (1) designating common carriers which shall be eligible to receive universal service support under § 254; (2) defining the services that will be supported by Federal universal service support mechanisms under § 254(c); and (3) advertising the availability of such services and the charges therefor using media of general distribution. Section 214(e)(2) governs designation of eligible telecommunications carriers by State commissions. Section 214(e)(3) governs designation of eligible telecommunications carriers for un-served areas.

[5] See *In Re FCC 11-161*, 753 F.3d at 1120 ("Congress appears to grant plenary authority to the FCC through § 251...."); *id* at 1046 ("nothing in the language of subsection (c)(1) serves as an express or implicit limitation on the FCC's authority to determine what a USF recipient may or must do with those [USF] funds."), *id.* ("as the FCC suggests, it is reasonable to conclude that Congress left a gap to be filled by the FCC, i.e., for the FCC to determine and specify precisely how USF funds may or must be used.), *id.* at 1047 ("Because Congress instead chose to utilize broader language, it was certainly reasonable for the FCC to have concluded

However, none of the petitioners in that matter brought the specific challenge raised here – that the FCC acted outside of the scope of 47 U.S.C. § 254(h)(1)(A) when it issued a regulation imposing a Regulatory Cap on the Rural Health Care program. FCC may not claim "plenary authority to act within a given area simply because Congress has endowed it with some authority to act in that area." *Am. Library Ass'n. v. F.C.C.*, 406 F.3d 689, 708 (D.C. Cir. 2005).

Congress did not use broad language or leave a statutory gap in its provisions creating the support entitlement under the Rural Health Care program. Section 254(h)(1)(A)'s use of the mandatory language "shall" and "entitled" distinguishes the language establishing the Rural Health Care program from other provisions in the Act that conferred broader authority on the FCC. The majority in *In Re FCC 11-161* noted that Congress' use of the word "shall" in Section 254(b) of the Act "indicates a mandatory duty on the FCC" and limited the agency's discretion,[6] stating that "FCC may exercise its discretion to balance the principles [in § 254(b)] against one another when they conflict, but may not depart from them altogether to achieve some goal." *In Re 11-161*, 753 F.3d at 1055 (emphasis supplied) (quoting *Qwest Corp. v. F.C.C.*, 258 F.3d 1191, 1200 (10th Cir. 2001)).

The regulation at 47 C.F.R. § 54.675 was a wholesale departure from the statutory language of Section 254(h)(1)(A), which provides that telecommunications carriers "shall" provide services to rural HCPs upon request and "shall be entitled" to have the specified rate differential "treated as a service obligation as part of its obligation to participate in the

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that the language was intended as an implicit grant of authority to the FCC to flesh out precisely what "facilities" and "services" USF funds should be used for.").

[6] 47 U.S.C. § 254(b) states, "[t]he Joint Board and the Commission shall base policies for the preservation and advancement of universal service on [various enumerated principles]").

mechanisms to preserve and advance universal service," without limitation. The FCC identified no statutory authority to impose the Regulatory Cap on this program, and failed to explain why $400 million was an appropriate limit on distribution of the USF funds entrusted to USAC. The preamble in the Federal Register publishing the final regulation on March 1, 2013 (78 FR 13936) lacks any substantive discussion of the origin or reason for the cap, which is remarkable for such a major administrative departure from the statute. Regardless of FCC's goal in creating the Regulatory Cap, such a departure from the clear mandatory statutory language lies beyond the FCC's authority to implement Congress' mandate.

Further, the FCC's regulation at 47 CFR § 54.675 requires the HCPs, rather than the carriers to whom the entitlement is owed, to request funding from the FCC Administrator. The result is that the burden of any shortfall in RHC funding falls on the HCPs rather than the carriers. The Act, however, requires only that health care providers make a "bona fide request" for service to the carriers, and then requires that the carriers provide the requested service at certain rates. 47 U.S.C. § 254(h)(1)(A)("A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State."). The statute does not permit the FCC to impose a financial burden on the HCPs by limiting the amount of RHC funding available and then shifting the burden of that limited funding from the carriers to the HCPs. The FCC regulations do both, and are thus contrary to statute and in excess of the FCC's statutory authority.

In short, the Telecommunications Act includes a mandatory directive to ensure that rural healthcare providers, including Indian tribes and tribal health organizations, pay no more than their urban counterparts. 47 U.S.C. § 254(h)(1)(A). The FCC and the USAC may not ignore that statutory mandate by invoking a regulatory cap on payments. *See, e.g., Salazar v. Ramah Navajo*

Chapter, 567 U.S. 182 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the Supreme Court held that full payment of indirect costs to Indian tribes was required, even though the governing law stated that "the provision of funds under this chapter is subject to the availability of appropriations...." 25 U.S.C. § 5325. The Telecommunications Act does not condition USF funds (which are collected from service providers and not appropriated by Congress) on availability, but simply provides that carriers providing service to rural HCPs "shall be entitled" to the rate differential. FCC has made no claim that the USF cannot completely fulfill the entire demand for Rural Health Care program funds, and even if such a shortfall existed, its obligation to BBAHC and the carriers that serve BBAHC would continue.[7]

1997 FCC Universal Service Order

Following the passage of the Telecommunications Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No. 96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, and that the Telecommunications Act created a right to federal funding:

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[7] See also *Cherokee Nation of Okla. v. Leavitt*, 543 U.S. 631, 637 (2005)("[the] Government normally cannot back out of a promise on grounds of 'insufficient appropriations,' even if the contract uses language such as 'subject to the availability of appropriations,' and even if an agency's total lump-sum appropriation is insufficient to pay all the contracts the agency has made."); see also *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892) (insufficiency of an appropriation does not cancel the obligations of the federal government).

> Section 254(h)(1)(A) grants the right to receive federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state."

FCC Universal Service Order at 335-36 (emphasis supplied).

This language is clear on its face: the FCC acknowledged that RHC funding is mandatory and that the Act creates a right to receive these services. Despite this clear mandate, and instead of structuring the program at the outset as a program with mandatory funding obligations that spring from the statute itself, the FCC arbitrarily established a $400 million cap on RHC funding to the HCPs, which led to the current shortfall. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

The Regulatory Cap had not affected BBAHC or similarly situated rural HCPs until recently because USAC was able to accommodate all funding requests and needs within the capped funds. In 2016, however, the Regulatory Cap was exceeded for the first time because of increasing program utilization. If the initial $400 million cap had been increased in pace with inflation since 1997, it should now (at a minimum) be funded at $571 million based on the GDP-CPI.[8] Despite the increased need, the FCC has kept the $400 million cap in place in violation of its statutory obligations to fully fund all "bona fide" service requests.

It is telling that, when it established the cap, the FCC did not anticipate that it would be reached. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a specific amount to Congress, not to require a *pro rata* formula for distribution. The FCC stated, "[w]e estimate that the maximum cost of providing services eligible for support

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[8] Notice of Proposed Rulemaking and Order, FCC 17-164, ¶ 16 (December 18, 2017).

under section 254(h)(1)(A) is $366 million, if all eligible health care providers obtain the maximum amount of supported services to which they are entitled." *FCC Universal Service Order* at 366 (emphasis supplied). In the Preamble to its rulemaking creating the Regulatory Cap, less than five years ago, the FCC argued that the "cap" itself was of no concern, from an apportionment of funding perspective, since the FCC had no reason to think it would ever be reached: "Given the historical utilization of RHC support and the implementation timetable for funding year 2013, we do not currently anticipate that demand will exceed the $400 million cap in FY 2013 or for the foreseeable future." 78 Fed. Reg. 13,964 (March 1, 2013).

The fact that the FCC has recognized the right of HCPs to receive these services, as well as the fact that the FCC never intended the Regulatory Cap to impact the program (because the FCC did not believe that the cap would be reached) support waiver in this instance. The Regulatory Cap is now impacting the right and ability of BBAHC to access mission critical services while maintaining the integrity of its health care programs in extremely isolated, rural areas of Alaska. In addition to violating statutory mandates, application of the Regulatory Cap is not in line with the FCC's own policies and priorities as recognized in the 1997 FCC Universal Service Order and elsewhere.

Federal Trust Responsibility and the 2000 FCC Tribal Policy Statement

Federal law and FCC policy provide additional justifications for waiver of the cap as it impacts BBAHC specifically. BBAHC is a regional organization formed by sovereign Alaska Native tribes, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by BBAHC in the Bristol Bay region is a part of the federal trust responsibility to Tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of the United States, the Supreme Court issued decisions defining important aspects of the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.* The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with Indian Tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" was reinforced by Congress in statute. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care in 2010 with passage of the Indian Health Care Improvement Act, in which the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that

will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to Tribes and Alaska Native villages that the FCC's responsibility to support the mission critical aspects of BBAHC's rural health care system must be understood. The FCC took up the matter of its own relationship with Tribes and Alaska Natives in June 2000 with its Policy Statement entitled "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes."[9] In that Policy Statement, the FCC stated that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

To implement this trust responsibility, the FCC committed to "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives ... that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also committed that the agency, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* Further, the FCC would "endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

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[9] Available at https://www.fcc.gov/Bureaus/OGC/Orders/2000/fcc00207.doc (last accessed March 21, 2018).

The BBAHC is a co-signer of the ATHC and has, over the years, entered into multiple FAs with the IHS through which it has assumed the United States' responsibility to provide health care to beneficiaries and others in the BBAHC region. In delivering these responsibilities in the region over the past decades, BBAHC has come to rely upon RHC funding through the USF to ensure that mission critical connectivity is available, without which BBAHC's ability to provide these federal programs and the federal trust responsibilities would be significantly impacted. BBAHC, in turn, relies on the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between BBAHC and the United States.

In this case, the term "shall be entitled" in § 254(h)(1)(A) is unambiguous, and creates a mandatory funding entitlement. Additionally, however, the FCC's obligation is reinforced by its practice of interpreting questionable terms in favor of federally recognized Tribes such as BBAHC's members "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes." *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003). Consequently, even assuming that the phrase "shall be entitled to have an amount equal to the difference" between rates is ambiguous, any ambiguity must be resolved in favor of the tribal interests involved. "[S]tatutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit." *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985).

VI. Relief Sought

The USAC now administers almost $10 billion annually in the Universal Service Fund.[10] Funding for broadband-enabled health care is needed today more than ever, and the $400 million Regulatory Cap established by the FCC was not consistent with the statutory language mandating full RHC funding.

The FCC, in denying tribes and tribal health organizations like BBAHC full funding for these mission critical services, has violated the Telecommunications Act, the FCC's own Tribal Policy Statement, and the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. The burgeoning demand for Universal Service Fund Rural Health Care funds in funding year 2016 and funding year 2017 demonstrates clearly that this arbitrary cap is no longer sufficient.

For the foregoing reasons, BBAHC requests that the FCC waive application of 47 C.F.R. § 54.675 and direct the USAC RHC staff to commit full funding for all of BBAHC's funding year 2017 funding requests without proration.

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[10] USAC website, http://www.usac.org/about/default.aspx (last accessed March 21, 2018).

Respectfully submitted this 2nd day of April, 2018.

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On behalf of
Bristol Bay Area Health Corporation

EXHIBIT A

FUNDING REQUESTS AND COMMITTED FUNDING FOR BBAHC

Table 1 – Funding Requests and Committed Funding for BBAHC

FY 2017 BB Service Provider and SPIN Number	**Health Care Provider (HCP) and HCP Number**	**Form 465 Application Number**	**Funding Request Number (FRN)**	**Total Funding Amount**	**Committed Funding Amount from USAC**	**Amount in Dispute Due to Pro Rata Distribution**
GCI-143001199	Clarks Point Health Clinic 10974	43162387	17105901	$10,884.00	$9,186.59	$1,697.41
GCI-143001199	Aleknagik Health Clinic 10981	43162391	17106131	$10,884.00	$9,186.59	$1,697.41
GCI-143001199	Manokotak Clinic 11005	43162424	17147211	$10,884.00	$9,186.59	$1,697.41
					Total:	**$5,092.23**

EXHIBIT B

USAC FUNDING COMMITMENT LETTERS

From: rhc-assist@usac.org
Sent: Friday, March 16, 2018 3:04 PM
To: Johanna Darrough; Tara L. Flensburg
Subject: RHC Telecommunications Program - Funding Commitment Letter (FCL) - HCP # 10974 - FRN 17105901

Date:	16-Mar-2018
Program:	Telecommunications Program
Funding Year:	2017
Health Care Provider (HCP) Name:	Bristol Bay Area Health Corporation dba Clarks Point Health Clinic
HCP Number:	10974
FCC Form 465 Application Number:	43162387
Funding Request Number (FRN):	17105901

The Universal Service Administrative Company (USAC)'s Rural Health Care (RHC) Program completed the review of the Funding Request and Certification Form (FCC Form 466) submitted on behalf of the HCP referenced above. Based on the information provided, USAC determined that the HCP is eligible for the funding shown below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location:	**58.833347, -158.55, P.O. Box 49, Clark's Point, AK, 99569**
Service Type:	**MPLS**
Bandwidth:	**15 Mbps**
Service Provider Name:	**GCI Communication Corp**
SPIN/498 Filer ID:	**143001199**
Billing Account Number:	**RH000220002**
Contract ID:	**901423**
Contract Friendly Name:	**HC-471-01**
Contract Expiration Date:	**22-Jun-2021**

Funding Start Date	Funding End Date	Months of Funding	Non-Recurring Funding Amount	Monthly Recurring Funding Amount	Total Funding Amount	Committed Funding Amount*
01-Jul-2017	30-Jun-2018	12.00000	$0.00	$907.00	$10,884.00	$9,186.59

The pro-rata factor for this filing window period is 84.40458%*

*This funding request was submitted during the FY2017 Filing Window 1 period. All qualifying requests (i.e., FCC Forms 466) submitted by the close of the filing window period are guaranteed to receive at least a percentage of the funding requested. For each filing window period, if the total demand for RHC Program funding exceeds the total remaining funding available for the funding year, USAC will apply a pro-rata factor to each funding request. Learn more about funding request filing window periods here.

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this FCL is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal*.

Contract/Service Agreement Endorsement Determination: Evergreen

Evergreen: For the life of the contract, the HCP is exempt from competitive bidding for the service(s) identified above, and therefore is not required to post a FCC Form 465 (Description of Services Requested and Certification Form). However, the HCP must submit the FCC Form 466 (and the FCC Form 467) to receive funding each year.[1]

The Evergreen endorsement and competitive bidding exemption end when the contract expires. The HCP must participate in competitive bidding at the expiration of the contract. This means that the HCP must post a new FCC Form 465 and wait 28 days before selecting a new service provider (or when continuing the formerly contracted service on a month-to-month basis). Funding Requests (FCC Form 466) must be subsequently submitted in all cases.

If, at any time, the funded services are not provided to the HCP, or the HCP is not otherwise receiving the approved funding, the HCP must notify USAC immediately.

The HCP entered Billing Account Number, certifications, and all other information provided on FCC Forms 465, 466, and 467 may be subject to audit by USAC and the FCC.[2] HCPs are subject to audits and other reviews that USAC and/or the FCC may undertake to ensure that the universal service support is used in compliance with FCC program rules. If the funded service(s) is not used in compliance with program rules, program participants will be subject to enforcement activities and other means of recourse by USAC and other appropriate federal, state, and local authorities.

Next Steps

Submit an FCC Form 467 (*Connection Certification Form*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services (and when those services ended, if prior to the end of the funding year). To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or FRN, and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Errors and Corrections:

If the funding amount, funding dates, or contract information is incorrect or missing, please contact the Rural Health Care Program Help Desk immediately by phone at (800)-453-1546 or by email at RHC-Assist@usac.org.

Appeals:

Before appealing a funding decision, contact the RHC Help Desk. To appeal this funding decision, deliver a letter of appeal to USAC within 60 days of the date of this letter. Detailed instructions for filing appeals are

available at: http://www.usac.org/about/about/program-integrity/appeals.aspx. Details about and definitions of all terms used in this FCL are provided on the USAC website (www.usac.org/rhc).

For More Information:

Please do not reply directly to this email, as emails to this account will not be delivered to the RHC Program team. For questions or assistance, contact the Rural Health Care Program Help Desk at (800)-453-1546 or by email at RHC-Assist@usac.org.

For more information about the Telecommunications Program application process, refer to the Telecom Program Process Overview web page on the USAC web site at http://www.usac.org/rhc/telecommunications/process-overview/default.aspx/.

For more information about the FCC Form 467, visit the Telecommunications Program Forms web page at http://www.usac.org/rhc/telecommunications/tools/forms/.

The primary account holder will be copied on this and all correspondence from USAC related to this HCP.

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[1] 47 C.F.R. 54.623(d).
[2] 47 C.F.R. 54.619(c).

From: rhc-assist@usac.org
Sent: Friday, March 16, 2018 3:04 PM
To: Johanna Darrough; Tara L. Flensburg
Subject: RHC Telecommunications Program - Funding Commitment Letter (FCL) - HCP # 10981 - FRN 17106131

Date:	16-Mar-2018
Program:	Telecommunications Program
Funding Year:	2017
Health Care Provider (HCP) Name:	Bristol Bay Area Health Corporation dba Aleknagik Health Clinic
HCP Number:	10981
FCC Form 465 Application Number:	43162391
Funding Request Number (FRN):	17106131

The Universal Service Administrative Company (USAC)'s Rural Health Care (RHC) Program completed the review of the Funding Request and Certification Form (FCC Form 466) submitted on behalf of the HCP referenced above. Based on the information provided, USAC determined that the HCP is eligible for the funding shown below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location:	**59.279283 -158.622603, PO Box 73, Aleknagik, AK, 99555**
Service Type:	**MPLS**
Bandwidth:	**15 Mbps**
Service Provider Name:	**GCI Communication Corp**
SPIN/498 Filer ID:	**143001199**
Billing Account Number:	**RH000220002**
Contract ID:	**901423**
Contract Friendly Name:	**HC-471-01**
Contract Expiration Date:	**22-Jun-2021**

Funding Start Date	Funding End Date	Months of Funding	Non-Recurring Funding Amount	Monthly Recurring Funding Amount	Total Funding Amount	Committed Funding Amount*
01-Jul-2017	30-Jun-2018	12.00000	$0.00	$907.00	$10,884.00	$9,186.59

The pro-rata factor for this filing window period is 84.40458%*

*This funding request was submitted during the FY2017 Filing Window 1 period. All qualifying requests (i.e., FCC Forms 466) submitted by the close of the filing window period are guaranteed to receive at least a percentage of the funding requested. For each filing window period, if the total demand for RHC Program funding exceeds the total remaining funding available for the funding year, USAC will apply a pro-rata factor to each funding request. Learn more about funding request filing window periods here.

Note that the funding end date will coincide with the contract expiration date. Therefore, if the contract ends during this funding year, the HCP must participate in competitive bidding before selecting a new service provider (or continuing formerly contracted services on a month-to-month basis) to be eligible for funding for the entirety of the funding year.

It is the HCP's responsibility to review and verify that all information on this FCL is accurate. All account holders and the service provider listed on the form have received this FCL, and it is saved in the *My Documents* section of *My Portal.*

Contract/Service Agreement Endorsement Determination: Evergreen

Evergreen: For the life of the contract, the HCP is exempt from competitive bidding for the service(s) identified above, and therefore is not required to post a FCC Form 465 (Description of Services Requested and Certification Form). However, the HCP must submit the FCC Form 466 (and the FCC Form 467) to receive funding each year.[1]

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Next Steps

Submit an FCC Form 467 (*Connection Certification Form*), which confirms receipt of the services for which funding has been approved, and the date on which the service provider began providing those services (and when those services ended, if prior to the end of the funding year). To submit the FCC Form 467, go to the *My Forms* tab of *My Portal* and find the applicable Form 466 or FRN, and click on the "Create 467" button. Once the Form 467 is approved, the HCP and the service provider will receive a copy of the HCP Support Schedule (HSS). Receipt of the HSS means that the service provider must begin crediting the HCP for the funding amount (if it has not yet done so) and may begin to invoice USAC.

Errors and Corrections:

If the funding amount, funding dates, or contract information is incorrect or missing, please contact the Rural Health Care Program Help Desk immediately by phone at (800)-453-1546 or by email at RHC-Assist@usac.org.

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available at: http://www.usac.org/about/about/program-integrity/appeals.aspx. Details about and definitions of all terms used in this FCL are provided on the USAC website (www.usac.org/rhc).

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The primary account holder will be copied on this and all correspondence from USAC related to this HCP.

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[1] 47 C.F.R. 54.623(d).
[2] 47 C.F.R. 54.619(c).

From: rhc-assist@usac.org
Sent: Friday, March 16, 2018 3:04 PM
To: Johanna Darrough; Tara L. Flensburg
Subject: RHC Telecommunications Program - Funding Commitment Letter (FCL) - HCP # 11005 - FRN 17147211

Date:	16-Mar-2018
Program:	Telecommunications Program
Funding Year:	2017
Health Care Provider (HCP) Name:	Bristol Bay Area Health Corporation dba Manokotak Clinic
HCP Number:	11005
FCC Form 465 Application Number:	43162424
Funding Request Number (FRN):	17147211

The Universal Service Administrative Company (USAC)'s Rural Health Care (RHC) Program completed the review of the Funding Request and Certification Form (FCC Form 466) submitted on behalf of the HCP referenced above. Based on the information provided, USAC determined that the HCP is eligible for the funding shown below. Additionally, if the HCP submitted a contract or service agreement with the form, the outcome of the contract review is included in this letter.

HCP Physical Location:	**58.980381 -159.055767, P.O. Box 129, Manokotak, AK, 99628**
Service Type:	**MPLS**
Bandwidth:	**15 Mbps**
Service Provider Name:	**GCI Communication Corp**
SPIN/498 Filer ID:	**143001199**
Billing Account Number:	**RH000220002**
Contract ID:	**901423**
Contract Friendly Name:	**HC-471-01**
Contract Expiration Date:	**22-Jun-2021**

Funding Start Date	Funding End Date	Months of Funding	Non-Recurring Funding Amount	Monthly Recurring Funding Amount	Total Funding Amount	Committed Funding Amount*
01-Jul-2017	30-Jun-2018	12.00000	$0.00	$907.00	$10,884.00	$9,186.59

The pro-rata factor for this filing window period is 84.40458%*

*This funding request was submitted during the FY2017 Filing Window 1 period. All qualifying requests (i.e., FCC Forms 466) submitted by the close of the filing window period are guaranteed to receive at least a percentage of the funding requested. For each filing window period, if the total demand for RHC Program funding exceeds the total remaining funding available for the funding year, USAC will apply a pro-rata factor to each funding request. Learn more about funding request filing window periods here.

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The primary account holder will be copied on this and all correspondence from USAC related to this HCP.

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[1] 47 C.F.R. 54.623(d).
[2] 47 C.F.R. 54.619(c).